



*MaineCare Services*  
An Office of the  
Department of Health and Human Services

**FOR DISCUSSION**  
**DRAFT**  
**PURPOSES ONLY**

# MaineCare

## Design Management Committee

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January 30, 2012

<http://www.maine.gov/dhhs/oms/vbp>

# Agenda

## Agenda

- Welcome & Introductions
- Health Homes: CMS Requirements
- Maine's proposal
  - Medical Homes and the PCMH Pilot
  - Community Care Teams
- Health Homes RFI Responses
- Timeline
- Discussion

# CMS Health Home Requirements: Services & Match

- CMS will provide a 90/10 match for Health Home services to eligible members for eight quarters.
- State may submit additional SPA(s) to expand Health Homes and restart the clock either. Expansion must either be by:
  - » Discrete geographic area
  - » Population
- Required Health Home services include:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings
  - Individual and family support
  - Referral to community and social support services
  - Use of health information technology (HIT)
  - Prevention and treatment of mental illness and substance abuse disorders
  - Coordination of and access to preventive services, chronic disease management, and long-term care supports

# CMS Health Home Requirements: Member Eligibility

Health Homes may serve individuals with:

- Serious and persistent mental illness (SPMI)
- Two or more chronic conditions
- One chronic condition and who are at risk for another

Chronic conditions include

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Being overweight (BMI > 25).

Dual eligible beneficiaries cannot be excluded from Health Home services.

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# Maine's Health Homes Proposal



**Medical Homes**

**Community Care Teams (CCTs)**



**Health Homes**

# Defining Medical Home Model

“A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

- American Academy Pediatrics (1964)



# Maine PCMH Pilot




## Practice “Core Expectations”

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

# Maine PCMH Pilot Practices Ownership Types

## Legend

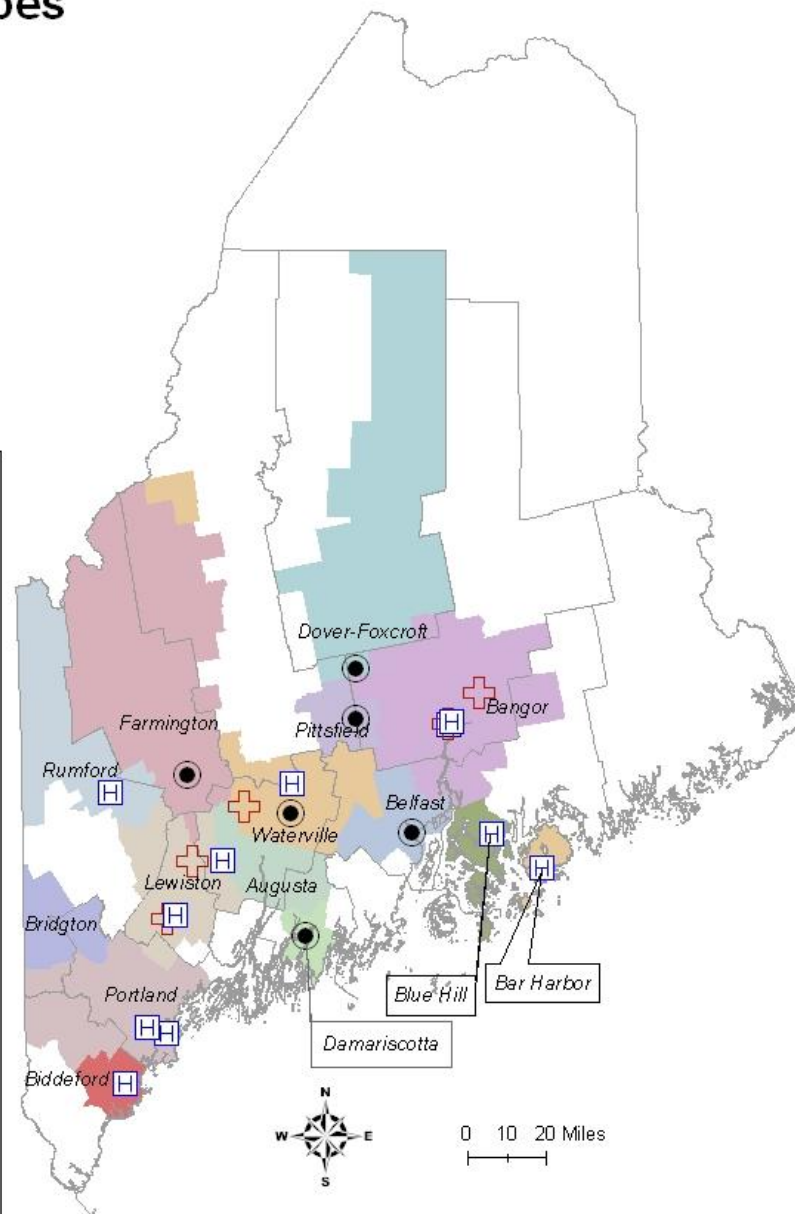
### Ownership Type

-  FQHC
-  Private
-  H-O

— County lines

### Hosp. Service Areas w. Pilot Practices

-  Augusta
-  Bangor
-  Bar Harbor
-  Belfast
-  Biddeford
-  Blue Hill
-  Bridgton
-  Damariscotta
-  Dover-Foxcroft
-  Farmington
-  Lewiston
-  Pittsfield
-  Portland
-  Rumford
-  Waterville



# Phase 2 Pilot Expansion

- 20 new adult practices to be selected for participation in multi-payer Pilot
- Expectations:
  - Strong leadership for change
  - NCQA PCMH recognition (Level 1 or higher)
  - Fully implemented EMR
  - Commitment to implement Pilot Core Expectations

# Other Medical Homes in Maine

- In total, there are 82 practices recognized as Medical Homes by the National Committee for Quality Assurance (NCQA).
- In addition, 14 Federally Qualified Health Centers (FQHCs) have been selected as part of CMS's Advanced Primary Care demonstration. These practices must attain NCQA certification within the next year.

# Health Homes: Role of Community Care Teams

## Medical Homes

### Community Care Teams (CCTs)

- Medicare joined the multi-payer PCMH pilot this month as part of Medicare's Multi-Payer Advance Primary Care Practice (MAPCP) grant that Maine received.
- As part of the MAPCP demo, Maine has implemented eight Community Care Teams that will work with the PCMHs to coordinate and connect the highest need patients to additional healthcare and community resources.
- The 20 additional practices to join the multi-payer PCMH pilot in January 2013 must also connect with a new or existing CCT to serve their patients.

# Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)

# ME PCMH Pilot CCTs

- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Comm Health Cntr/MDI, Seaport FP)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell
- Eastern Maine Homecare
- Kennebec Valley (MEGenl)
- MMC
- PCHC

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# Who Responded to the RFI

## Twenty eight Responders:

- **Health Systems (5)**

- Eastern Maine Health
- MaineGeneral
- MaineHealth
- Mercy Hospital
- St. Mary's Hospital

- **Behavioral Health Organizations (11)**

- Assistance Plus
- Aroostock Mental Health Center
- Crisis and Counseling Centers
- Motivational Services
- Community Health and Counseling Services
- Amistad (also included as Advocacy Organization)
- Merrimack River Medical Services,
- Behavioral Health Community Collaborative (5 agencies)
- Providence Service Corp
- Beacon Health Strategies
- Charlotte White Center

# Who Responded to the RFI

- **Health Plans/Administrative Services Organization (4)**
  - Anthem
  - APS
  - Magellan Health Services
  - Outcomes Pharmaceutical
- **Long Term and Home Care Services (3)**
  - Seniors Plus
  - OHI
  - Androscoggin Home Health and Hospice
- **Advocacy Groups (3)**
  - NAMI
  - Maine Equal Justice Partners/Consumers for Affordable Health Care
  - Amistad
- **Primary Care(2)**
  - Maine Primary Care Association
  - Dr. Jean Antonucci
- **Pharmacy (1)**
  - National Association Chain Drug Stores

# RFI Response: Health Homes

The RFI contained 2 questions about Health Homes:

(4.2.1) Interest and Ability

(4.2.2) Integration of Benefits for Dual Medicaid-Medicare Enrollees.

Most responders answered 4.2.1 in some detail, describing their participation in various PCMH models and their capacity to provide services. A far smaller number responded to 4.2.2 and those responses were quite general in nature.

## Interest in Health Home Participation:

- With the exception of Health Plan/ Administrative Service Organizations, a majority of respondents in all categories of organizations expressed interest in participating in Health Homes

### 4.2.1 Ability and Capacity

#### 1. Health Systems

- All responding health systems have created medical homes as part of their hospital-owned PCP practices and plan to expand their number.
- Many health system medical homes have achieved national certification (NCQA) or are working towards that goal.
- All responding health systems indicated they would be working with or providing their own Community Care Teams.

## Health Systems (cont'd)

- Health systems believe MaineCare members would benefit from being in a Health Home to receive better coordination and care management, particularly for chronic physical and mental conditions
- One health system described its team approach using multiple community outreach organizations and use of Peer/Patient Navigator model.
- CCT teams in one system are concentrated in two medical homes with highest volumes of MaineCare members
- One health system interested in system-wide implementation of medical homes for MaineCare members. Also interested in expanding current Medicare project transitioning patients from hospital to home to include MaineCare members in Health Homes.

## 2. Behavioral Health Organizations

- Many have provided care coordination management and plan to act as Community Care Team to existing medical homes
- Strong support for allowing BHOs to be designated as Health Homes for individuals with a primary mental health diagnosis
- Several are interested in becoming Health Homes for SPMI individuals, either through co-location or contract with primary care provider
- One request for creation of a Health Home within a Methadone Maintenance Treatment by integrating PCP services on site
- Most BHOs have capacity to do required Health Home functions except for medical care management, and a few expressed need for financial assistance to develop electronic health records
- Five BHO agencies are collaborating to develop IT capability.

## 3. Advocacy Groups

- Multiple desire contracts with Health Homes to provide peer/patient support services, family and individual supports
- MaineCare should incentivize Health Homes to contract with community partners
- Suggest requiring that Health Home with SPMI population hire at least one independent Peer/Patient Navigator.

## 4. Long Term Care and Home Health Agencies

- Capacity in providing CCT services to some Health Homes and interested in expanding that role to other practices

## 5. Health Plans/ASO

- One responder interested in providing wraparound services to Health Homes, to include provider engagement, member outreach, provider feedback, member stratification

## 4.2.2 Integration of Benefits for Dual Medicare-Medicaid Enrollees

- **Behavioral Health Organizations**

- Most responders did not answer this question or indicated they would need to establish contracts with local pharmacies
- One agency recommended their pharmacy management program, Psychotropic Drug Intervention Program, for complex populations like MME

- **Health Systems**

- One system described use of CCT for wraparound long-term services for high costs, high need population and ACT team work on medication management with SMI
- One system expressed interest in discussing improved coordination of care management integrated with pharmacy and long term supports and services

### **Health Plans**

- APS suggests partnerships with providers of ABD members who have good clinical and cost outcomes

# Maine Health Homes Proposal

## Stage A:

- Health Home = Medical Home practice + CCT (majority of payment weighted toward medical home)
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another

## Stage B:

- Health Homes = Community Mental Health Center CCT + Medical Home practice (majority of payment weighted toward CMHC CCT)
- Eligible Members:
  - Serious and Persistent Mental Illness

RFP/ Application: Practices will apply for the PCMH Expansion and the Health Homes Initiative through the one Quality Counts' application.

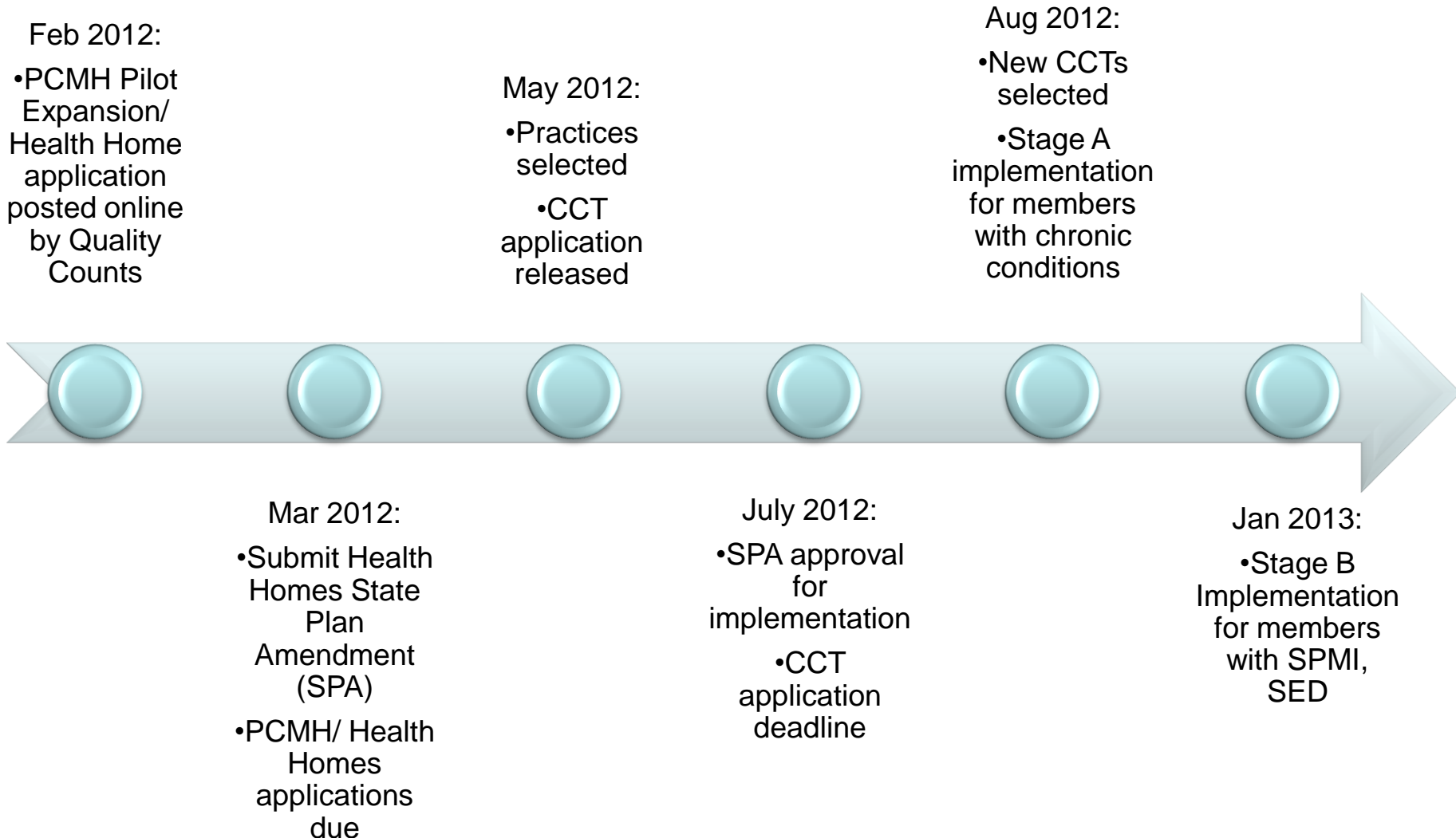
- The 20 top scoring practices (geographic area will be a factor in selection) will be selected for the multi-payer PCMH expansion.
- All other practices meeting the basic qualifications will be eligible to become a Health Home under MaineCare.
- CCTs will be selected through a separate Quality Counts application

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# Health Homes Timeline



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# Discussion Questions

- Staged implementation and application process
  - Include Washington and Aroostook Health Homes in Stage A or B, to ensure readiness of CCTs and allow for full 8 quarters of enhanced match?
  - Should the Community Mental Health Center CCTs for Stage B require a separate CCT application
- Is current level of specificity of the PCMH core expectations sufficient for CMS?
  - Specify CCT staff qualifications, licensure? (SAMHSA question)
  - Should Health Homes be required to institute specific depression and substance abuse screening tools /procedures? (SAMHSA question)
- Are additions to the model necessary to better ensure that the needs of children and individuals with behavioral health issues are met?
  - Require use of Peer/Patient Navigator services and/or other peer services? (RFI & Member Standing Committee feedback)
  - How may Health Homes address prescription drug abuse? Potential for partnership with Prescription Monitoring Plan? (SAMHSA question)
  - What else may be needed for the proposed model to fit the needs of children and teenagers? (SAMHSA question)
- Other?